Doc. 20

Government Operations and Audit Committee
Surveillance & Utilization Review Subsystem (SURS) Overview

- The goal of the SURS program is to:
  - Safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments
  - Assess the quality of services
  - Control utilization of services provided for under the Medicaid State Plan
- This is a federal requirement of the Centers for Medicare and Medicaid Services (CMS) and is applicable to all State Medicaid programs in order to receive Federal Medicaid funds.
- DSS staff as well as outside entities are used to meet the requirements of the program.
- The DSS SURS unit includes four (4) FTE that perform pre and post payment reviews of providers to ensure proper payments are made in accordance with all state and federal regulations.
- A number of approaches are used to identify potential overpayments including:
  - Creation and analysis of various exception reports to identify outliers that could trigger a more comprehensive review.
  - Pre and post payment review of claims and payment data.
  - Sampling of claim data weekly, monthly, or quarterly depending on the type of service to identify potential overpayments or irregular billing patterns.
  - Complaints, tips, and referrals may also generate a specific provider review.
- In addition to internal DSS resources, several targeted payment and utilization reviews are also conducted in conjunction with outside entities including:
  - Monthly inpatient hospital reviews with the State's Quality Improvement Organization (South Dakota Foundation for Medical Care). The QIO evaluates a sample of claims to determine medical necessity, appropriateness of billing.
  - Medicaid Integrity Contractors (MIC) audits completed every 3 years. Contractors are hired by the federal government to audit targeted provider groups and work with the state to identify potential overpayments for recovery. This process is new and South Dakota is just starting its first audit.
  - Payment Error Rate Measurement (PERM) review every 3 years targeted to ensure payment accuracy from eligibility determination through provider claims payment.
  - Referral of potential provider fraud cases to the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office.
- Review results are used to identify policy, rule, or computer system changes that can be implemented to reduce payment errors on the front end, vs catching them post payment.
- In FY2009 – recoveries of over $750,000 as well as savings of $178,000 related to pre-payment reviews and education of correct billing practices.